CHECK UP FROM THE NECK UP

Executive Force Preservation

Director, Health Services, Headquarters, U. S. Marine Corps

RDML Michael H. Anderson

Overview

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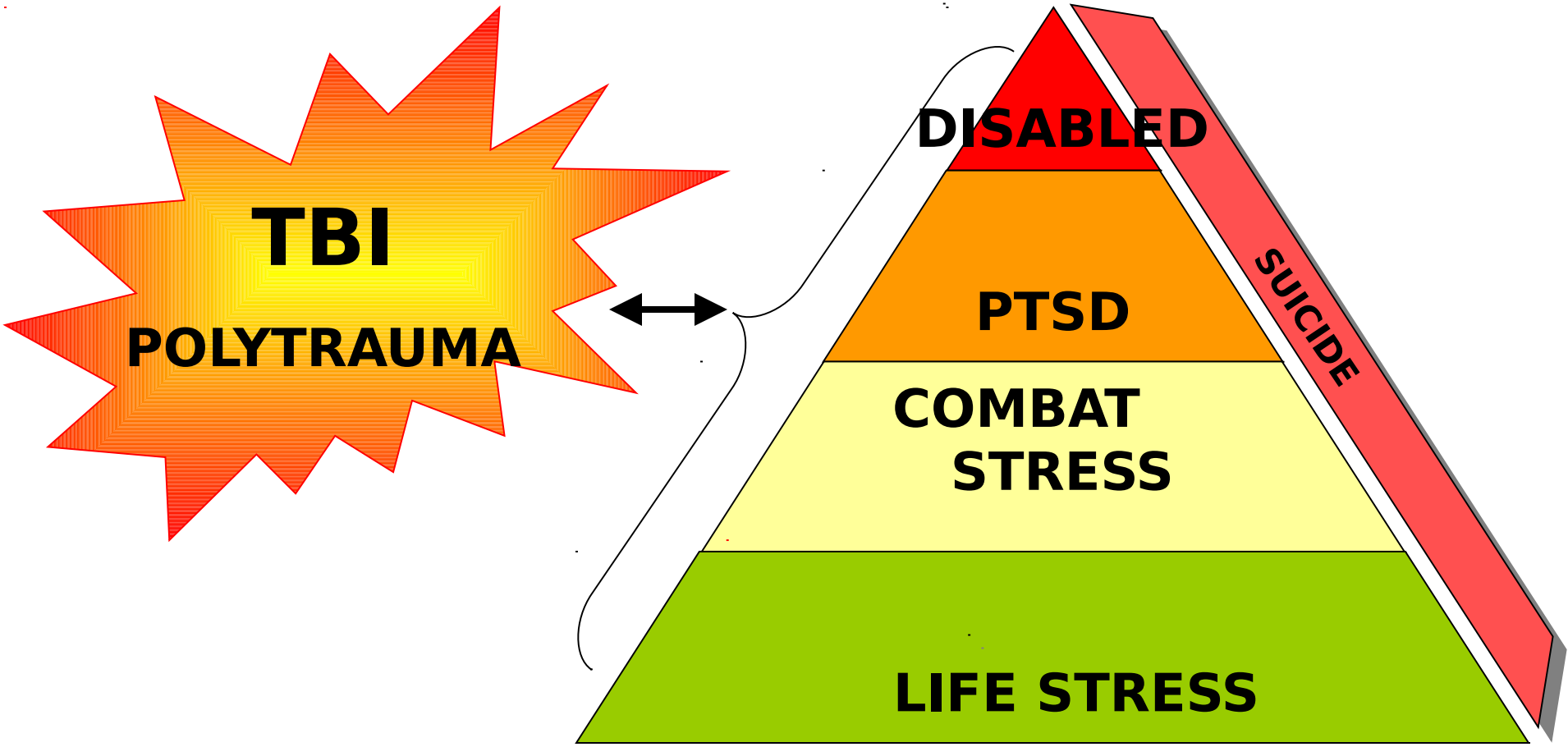

Mental Health of the Force

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- 20-30+% have stress issues that cause them problems at home or work any given day
- Approximately 5% meet diagnostic criteria for Post Traumatic Stress Disorder
- Most Marines with stress issues, even including PTSD, function well at work (and therefore most in chain of command unaware)
- Marine (not medical) part of solution set is Engaged Leadership
- Medical's role include embedded mental health support (OSCAR) and care for the medically "ill"

Stigma

- STIGMA: Marines worry that they will be treated DIFFERENTLY by their Marines and/or chain of command if they know about their receipt of psychological support/help
- This is true even when being treated differently is to offer additional help
- STIGMA is the number one reason why Marines who should seek help don’t do it
- THE RUB: how to balance engaged leadership with creating additional Stigma

Linkage Between Commanders and Medical Providers

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- Commanders have a right to know medical information about their Marines to ensure mission effectiveness and good order and discipline
- Specific questions, no fishing expeditions
- Clear policy and procedure will smooth the flow of information
- Recommend that the surgeon act as commander’s designated representative

I MEF

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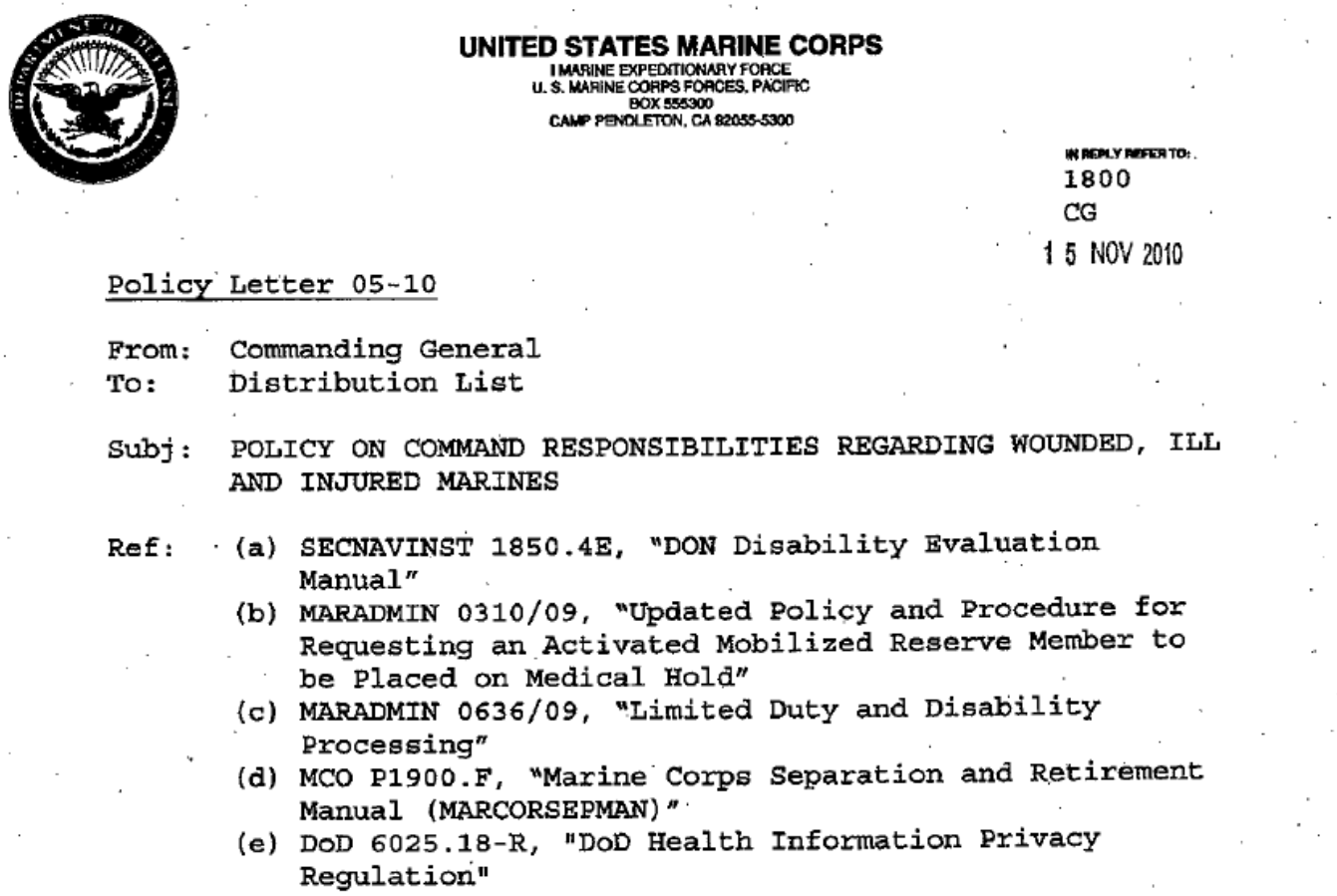
- I MEF recently created a policy that synthesizes many of the various laws, policies and directives that cover command information and notification



UNITED STATES MARINE CORPS
I MARINE EXPEDITIONARY FORCE
U. S. MARINE CORPS FORCES, PACIFIC
BOX 555300
CAMP PENDLETON, CA 92055-5300

IN REPLY REFER TO:
1800
CG
15 NOV 2010

Policy Letter 05-10

From: Commanding General
To: Distribution List

Subj: POLICY ON COMMAND RESPONSIBILITIES REGARDING WOUNDED, ILL AND INJURED MARINES

Ref: (a) SECNAVINST 1850.4E, "DON Disability Evaluation Manual"
(b) MARADMIN 0310/09, "Updated Policy and Procedure for Requesting an Activated Mobilized Reserve Member to be Placed on Medical Hold"
(c) MARADMIN 0636/09, "Limited Duty and Disability Processing"
(d) MCO P1900.F, "Marine Corps Separation and Retirement Manual (MARCORSEPMAN)"
(e) DoD 6025.18-R, "DoD Health Information Privacy Regulation"

Linkage Between Commanders and Medical Providers

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- Data comes from the medical record which must be turned into operationally useful information
- Experience and leadership will turn new physicians into medical officers who can generate that information
- Treat the medical data with care, respect Marine's privacy

Pre-existing Mental Health Conditions and Force Preservation

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- Screening for Suicide Risk: A Systematic Evidence Review for the U.S. Preventive Services Task Force, May 2004
- “Because of the complexity of studying the risk of suicide and the paucity of well-designed research studies, there is limited evidence to guide the primary care clinician’s assessment and management of suicide risk.”
- There is no screening test for suicide.
- Screening for suicide entails enormous costs due to many false positives
- What would you, as a commander, do differently with information about past mental health conditions? Would this improve Stigma or worsen it?

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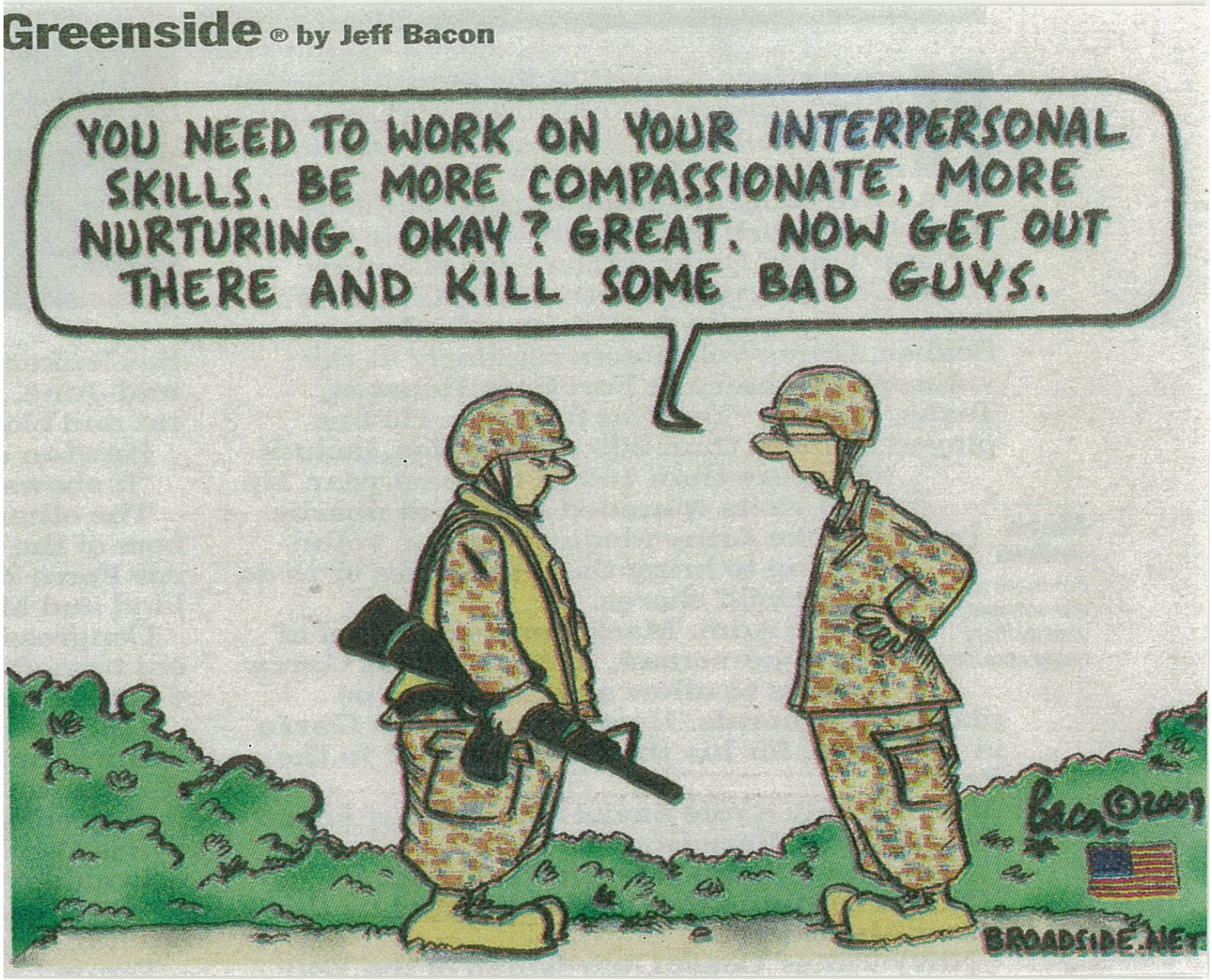
Greenside ® by Jeff Bacon
YOU NEED TO WORK ON YOUR INTERPERSONAL SKILLS. BE MORE COMPASSIONATE, MORE NURTURING. OKAY? GREAT. NOW GET OUT THERE AND KILL SOME BAD GUYS.
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BACK UP SLIDES

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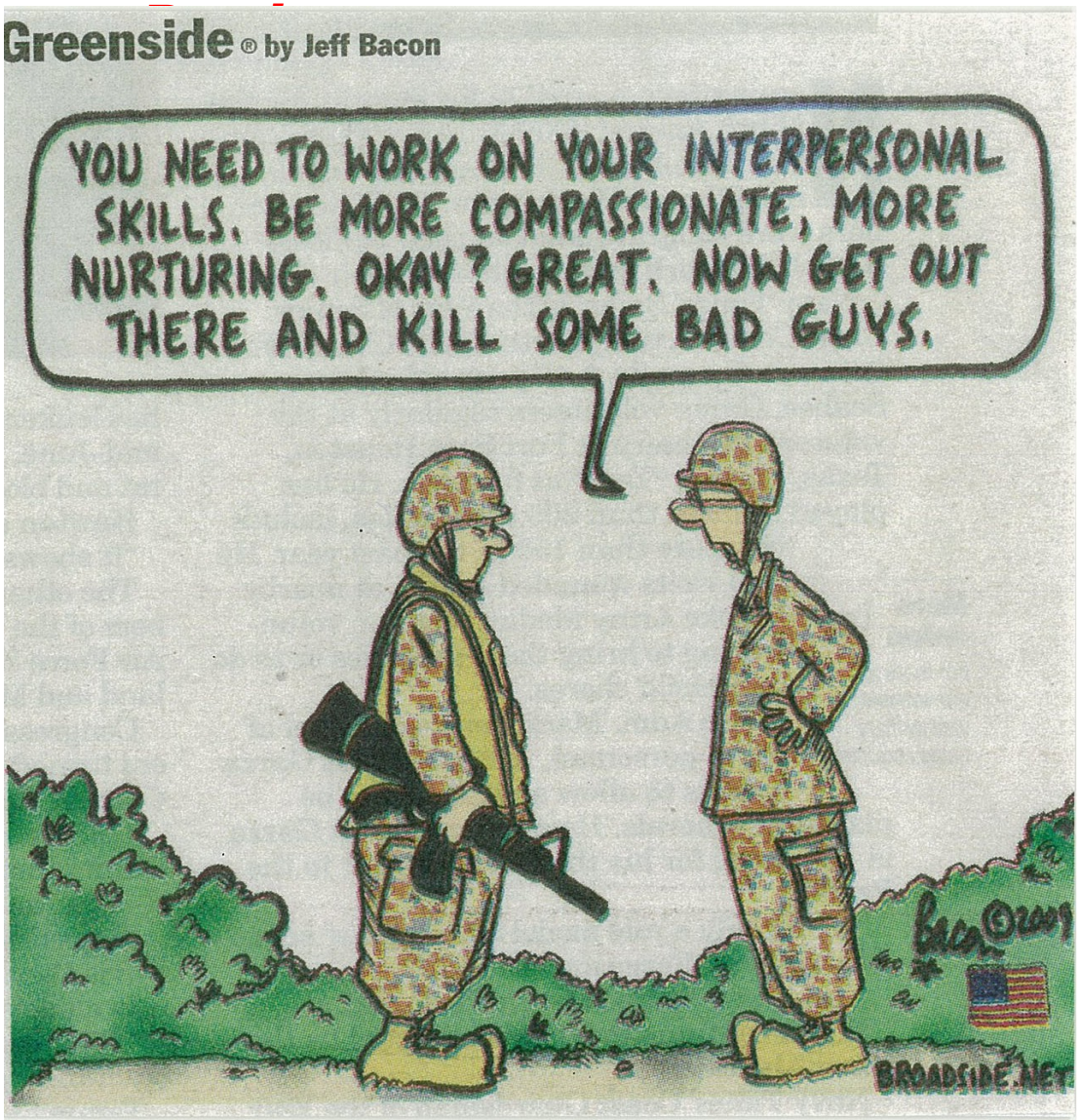
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Nearly perfect screening test

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Population	100,000	
Prevalence of Disease D	20	per 100,000
Sensitivity of Test T	99%	Percentage of persons with Disease D who test positive on Test T
Specificity of Test T	99%	Percentage of persons without Disease D who test negative on Test T
Positive Predictive Value of Test T for Disease D	1.94%	Percentage of people with positive Test T who have Disease D
Negative Predictive Value of Test T for Disease D	100.00%	Percentage of people with negative Test T who do not have Disease D
False positives per true positive (candidates eliminated per suicide prevented)		50.49495

	Has Disease D	Does not have Disease D	
Test positive	20	1,000	1,020
Test negative	0	98,980	98,980
	20	99,980	100,000

Good screening test

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Population	100,000	
Prevalence of Disease D	20	per 100,000
Sensitivity of Test T	90%	Percentage of persons with Disease D who test positive on Test T
Specificity of Test T	90%	Percentage of persons without Disease D who test negative on Test T
Positive Predictive Value of Test T for Disease D	0.18%	Percentage of people with positive Test T who have Disease D
Negative Predictive Value of Test T for Disease D	100.00%	Percentage of people with negative Test T who do not have Disease D
False positives per true positive (candidates eliminated per suicide prevented)		555.4444

	Has Disease D	Does not have Disease D	
Test positive	18	9,998	10,016
Test negative	2	89,982	89,984
	20	99,980	100,000

Average screening test

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Population	100,000	
Prevalence of Disease D	20	per 100,000
Sensitivity of Test T	70%	Percentage of persons with Disease D who test positive on Test T
Specificity of Test T	60%	Percentage of persons without Disease D who test negative on Test T
Positive Predictive Value of Test T for Disease D	0.03%	Percentage of people with positive Test T who have Disease D
Negative Predictive Value of Test T for Disease D	99.99%	Percentage of people with negative Test T who do not have Disease D
False positives per true positive (candidates eliminated per suicide prevented)		2856.571

	Has Disease D	Does not have Disease D	
Test positive	14	39,992	40,006
Test negative	6	59,988	59,994
	20	99,980	100,000